Conferees Nearing Accord on Health-Costs Bill

A House-Senate conference on legislation to protect the 32 million Americans enrolled in Medicare from catastrophic medical expenses is entering what members hope will be its final phase.

But some key points of contention remain that could delay a final agreement on the measure (HR 2470). House Speaker Jim Wright, D-Texas, said May 2 that the House will take up the conference report on the measure the week of May 16, provided the conference is finished.

Written offers exchanged between House and Senate conferees during April have resolved most of the differences between the versions of the bill passed by the House July 22, 1987, and by the Senate Oct. 27. *(Weekly Report p. 1169)*

House negotiators were expected to prepare another written offer for the Senate to consider upon returning May 9 from a weeklong recess, but they decided in a closed-door meeting May 5 that the time had come to resume face-to-face discussions with their Senate counterparts.

Optional or Voluntary?

Among the unresolved issues are two on which negotiators harbor deep philosophical differences.

Probably the most difficult to resolve will be the question of whether all Medicare enrollees will be required to pay for the new benefits envisioned under the bill.

The House version would require all beneficiaries enrolled in Part A, which covers inpatient hospital care, and with incomes high enough to trigger a special "supplemental" premium to pay for the new Part A benefits. Part B, which covers physician and some other outpatient costs, would remain optional.

By contrast, the Senate bill would allow beneficiaries, by dropping Part B coverage, also to avoid paying the portion of the supplemental premium that would finance the new Part A benefits. Those who choose that option, however, would not get new extended hospital coverage. The effect would be to create two tiers of hospital coverage — one that pays for an unlimited number of days, and the other that cuts off after a specified time.

"The [Finance] committee believed that the receipt of catastrophic coverage, and the payment of the associated premiums, should be on a voluntary basis like current Part B Medicare coverage," said the panel's report on its version of the bill.

But a number of House conferees find that unacceptable, fearing that if the program is voluntary, affluent and healthy elderly will opt out, leaving the poorer and sicker to foot the bill.

Making catastrophic coverage voluntary, said Rep. Ron Wyden, D-Ore. "chips away at the very underpinnings of the concept of this program as social insurance."

Conferees must still decide whether all Medicare enrollees will be required to pay for the new benefits envisioned under the bill.

Also supporting the position of making at least the Part A portion of the new program mandatory is the American Association of Retired Persons (AARP), one of the major backers of the bill. Requiring participation, said AARP in a letter to conferees, "extends federal catastrophic protection to the very broadest number of beneficiaries. In addition, by creating a very large risk pool, this provision enables Medicare to offer beneficiaries a wide range of benefits at the lowest cost."

Phase-in of Drug Coverage

But the AARP is closer to the Senate's position on another issue that has proved touchy: how to phase in new coverage of the cost of outpatient prescription drugs.

The House bill originally envisioned no delay in implementing the new benefit, which would pay 80 percent of the cost of drugs after an annual deductible has been met. The Senate bill called for its benefit, also 80 percent after a deductible, to be phased in over four years, with only certain classes of drugs being covered each year.

The House countered with its own phase-in proposal, which would cover all drugs from the outset but require a relatively high initial copayment by beneficiaries that would later drop to 20 percent.

House conferees, led by Ways and Means Health Subcommittee Chairman Fortney H. "Pete" Stark, D-Calif., who came up with the copayment idea, said that a phase-in by class of drug was unfair. It would be impossible, they said, to explain to a constituent needing one type of drug why Medicare refuses to pay for it at the same time the program is covering the costs for a neighbor's different type of drug.

"It's an election year, and there's a growing concern about asking people to pay right away for benefits they're only going to get in the future," says Wyden, who insists he has not made up his mind on the issue.

But Senate conferees remained adamant. One Senate staffer asserted that the House phase-in is not practical. Medicare administrators, the staffer said, need time to start up the new system of drug coverage. Allowing immediate coverage of all types of drugs could swamp the system with claims.

Senior-citizen groups are supporting the Senate plan — with a faster phase-in — for a very different reason.

Phasing in by the level of copayments, they fear, could tempt lawmakers to re-examine the drug benefit if costs are running too high. Congress might decide to stick with a relatively high copayment — say, 40 percent — instead of continuing the phase-in. On the other hand, these lobbyists say, drug-by-drug coverage is so inherently unfair that members will feel compelled to continue until the benefit is fully in place.

"It's short-term pain for long-term gain," said one senior-citizen lobbyist.

—*By Julie Rovner*